IVERMECTIN
ORDER FORM

Today's Date

3537 N Anthony Blvd
Fort Wayne, IN 46805

(260)373-1083
(260)739-3927
morethanapharmacy@protonmail.com

Patient Information

Patient Name: ____ Date of Birth: ____

Address: ____ City: ____ State: ____ Zip: ____

Phone: ____ Email: ____

Please check your weight from one of these columns

WEIGHT	DOSE	WEIGHT	DOSE	WEIGHT	DOSE	WEIGHT	DOSE
☐ 70-90	8MG	☐ 151-190	16MG	☐ 231-250	22MG	☐ 291-310	28MG
☐ 91-110	10MG	☐ 191-210	18MG	☐ 251-270	24MG	☐ Other: ____	
☐ 111-150	13.5MG	☐ 211-230	20MG	☐ 271-290	26MG		

CHECK ONE BOX BELOW

☐ **I HAVE COVID NOW** ☐ **I DO NOT HAVE COVID NOW** ☐ **I am not using this for COVID**

I WANT TO ORDER THE FOLLOWING

☐ **#15 for $30.00** Active Covid Protocol — Take 2 capsules for 5 days, then 1 every other day until symptoms are gone.

☐ **#30 for $50.00** **Prevention Protocol** — Take 1 capsule weekly. (30 Capsules = 6 months)

☐ QTY: ____ **@ $1.65 /capsule** — I would like a different quantity than the options listed above

The pharmacy can not guarantee potency beyond 6 months because clinical trials have not been conducted.

PRESCRIPTION

☐ **I do not have a prescription** for Ivermectin and need a physician to prescribe it. (Total: $25.00)

MAIL OPTIONS

☐ I would like to have my order filled the same day it is received and I will pick it up at the pharmacy.

☐ I would like to have my order filled the same day it is received AND mailed same day. (add $5.00 for standard shipping USPS)

☐ I would like to have my order filled the same day it is received, plus overnight shipping. (Price depends on the address but usually $30 - $40)

PLEASE NOTE: We cannot guarantee delivery times because of possible USPS delay that are out of our control. Thanks for understanding. We are happy to help with tracking your package, and we will definitely refund your money if it does not arrive when guaranteed.

Total Billed to Credit Card

Payment Details

Credit Card Type: ☐ VISA ☐ MasterCard ☐ AMERICAN EXPRESS ☐ DISCOVER

Name on Card ____ Zip Code: ____

Credit Card # ____

Exp Date ____ CCV # ____ **3-digit number on the back of Visa/MC or 4-digit number on the front of AmEx.**

Prescription - Prescriber Use Only

Date: ____ Ivermectin: ____ mg QTY: ____ Refill: X2

☐ **PREVENTION** — Take 1 capsule now, then 1 in 48 hours, then 1 capsule weekly for prevention. Quantity: #30 (6 month supply)

☐ **ACTIVE COVID** — Take 2 capsules (together) daily for 5 days, then 1 every other day until symptoms are gone. Quantity: #15

☐ **OTHER** ____

Phil Johnson, MD
3537 N Anthony Blvd
Fort Wayne, IN 46805
Ph: (260) 422-4757
NPI: 1306975263

Dispense As Written ____ May Substitute ____

Dr. Philip J. Johnson, M.D.

3537 N Anthony Blvd, Fort Wayne, IN 46805

Phone: (260) 422-4757 | Fax: (260) 422-8375 | Lic.# 01023461

Date Written: Name: DOB:

Address: Phone: Email:

Hydroxychloroquine 200mg (Used as antiviral for Covid) For severe cases take along with Ivermectin) **$30**

(NDC: 16571-0687-01)
QTY: #16
Sig: Take 2 tabs twice daily x 2 days, then 1 tab twice daily x 4 days.

Z-Pak (Antibiotic) **$15**

(NDC: 59762-2198-01)
QTY: #6
Sig: 2 now, then 1 tab daily after food x 4 more days. Take at the beginning of Covid to prevent Covid pneumonia.

Doxycycline 100mg (Antibiotic) **$15**

(NDC: 00143-9803-50)
QTY: #20
Sig: Take 1 capsule twice daily with food for 10 days.
(Note: Take at the beginning of Covid to prevent pneumonia or sinus infection. This antibiotic is used instead of a Z-Pak if someone has allergies or medical conditions that makes this safer. Hydroxychloroquine and azithromycin taken together can cause problems in some individuals.

Budesonide Respules 0.25mg/2ml or 0.5mg/2ml or 1mg/2ml (For use in Nebulizer Machine - Steroid, Anti-inflammatory) **$30**

NDC: 00115-1687-74 0.25mg/2ml
NDC: 00093-6816-55 0.5mg/2ml
NDC: 00093-6817-73 1.0mg/2ml
QTY: #60ml (1 box of 30 x 2ml)
Sig: Nebulize 1 ampule every 6 hrs as needed for COVID cough and wheeze to decrease inflammation in the lungs.

Benzonatate 200mg Caps (Cough Suppressant) **$15**

(NDC: 64380-0713-07)
QTY: #12
Sig: Take 1 capsule every 8 hrs with full glass of water for cough due to COVID

Ondansetron 4mg tabs (For nausea & vomiting) **$15**

(NDC: 57237-0077-10)
QTY: #10
Sig: Dissolve 1 tablet under tongue every 4 hrs to treat COVID related n/v

Albuterol Inhaler 90mcg/per puff (Rescue Inhaler for Breathing) **$25**

(NDC: 00781-7296-85)
QTY: #6.7gm (1 inhaler)
Sig: Inhale 1 or 2 puffs every 4-6 hrs for immediate help with breathing

Montelukast 10mg tabs (Leukotriene receptor antagonist to prevent inflammation) **$15**

(NDC: 29300-0220-10)
QTY: #30
Sig: One tab at bedtime to prevent inflammation in the lungs & nose for COVID or allergies

Budesonide Nasal Spray 32mcg/spray (Steroid, Anti-inflammatory for nose and sinus congestion. **$16**

(NDC: 60505-6129-02)
QTY: #8.43ml (1 inhaler)
Sig: Use 1 or 2 sprays morning and bedtime in each nostril while sniffing gently for nasal congestion.

Albuterol Inhalation Nebules (2.5mg/3ml) (For use in Nebulizer Machine for immediate help with breathing) **$15**

(NDC: 00378-8270-52)
QTY: #75ml (1 box of 25 vials)
Sig: Nebulize 1 ampule 3 to 4 times a day when needed for immediate relief of COVID related shortness of breath and wheezing.

Prednisone 20mg Tabs (Steroid, Anti-inflammatory) **$15**

(NDC: 00591-544305)
#13
Sig: Take 2 and 1/2 tabs (50mg) first thing in the morning for 5 days.
(Stops inflammation of lungs from Covid that results in breathing difficulties.)

Other Items Frequently Requested

Example: Nebulizer, Mucinex, Vitamin C, Vitamin D3, Zinc, Quercetin Glutathione, NAC, Silver Nasal Spray, RxCofix Nasal Spray, Bronchial Soothe and many other items.

Refill ☐ NR ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 1yr
Void 1 year from the date written

Dispense as Written

May Substitute

MEDICAL HISTORY AND ANNUAL PHYSICAL FORM

3537 N Anthony Blvd
Fort Wayne, IN 46805
(260)373-1083
(260)739-3927
morethanapharmacy@protonmail.com

Patient Information

Today's Date:

First: ______ Last: ______ DOB: ______ Phone: ______

Please list all allergies:

If you are female, are you pregnant now, or planning to become pregnant: ☐ Y ☐ N

Have you had COVID, if Yes, list date.____________ ☐ Y ☐ N Have you ever been hospitalized or had an operation? ☐ Y ☐ N

Please explain type of surgery and dates: ______

If you have more medications or medical history than can fit on the form, please write on the back of this form.

MEDICATION NAME--including OTC & herbs	REASON FOR TAKING

PAST MEDICAL HISTORY	DATE

MEDICAL CONDITIONS

Legend: PR=Present, PA=Past

1.GENERAL	PR	PA
Weight Loss	☐	☐
Fatigue	☐	☐
Memory Loss	☐	☐
2.HEENT	**PR**	**PA**
Headache	☐	☐
Visual Loss	☐	☐
Decreased Hearing	☐	☐
Sinus Pain	☐	☐
Hoarseness	☐	☐
Sore Throat	☐	☐
Trouble Swallowing	☐	☐
3.RESPIRATORY	**PR**	**PA**
Cough	☐	☐
Wheezing	☐	☐
4.BREAST	**PR**	**PA**
Breast Mass	☐	☐
Breast Pain	☐	☐
Skin Changes	☐	☐
5.HEMATOLOGY	**PR**	**PA**
Anemia	☐	☐
Bleeding Issues	☐	☐

6.CARDIOVASCULAR	PR	PA
Chest Pain	☐	☐
Irregular Heart Beat	☐	☐
Elevated Blood Pressure	☐	☐
Heart Disease	☐	☐
Shortness of Breath	☐	☐
Swelling of Limbs	☐	☐
7.ENDOCRINOLOGY	**PR**	**PA**
Diabetes	☐	☐
Excessive Thirst	☐	☐
Excessive Urination	☐	☐
Libido Change	☐	☐
8.GASTROINTESTINAL	**PR**	**PA**
Bloody Stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heart Burn	☐	☐
Jaundice	☐	☐
Kidney Stones	☐	☐
Nausea	☐	☐
Vomiting	☐	☐

9.MUSCULOSKELETAL	PR	PA
Joint Pain	☐	☐
Joint Swelling	☐	☐
Jaw Pain	☐	☐
10.NEUROLOGICAL	**PR**	**PA**
Blackouts	☐	☐
Dizziness	☐	☐
Seizures	☐	☐
Stroke	☐	☐
11.PSYCHIATRIC	**PR**	**PA**
Anxiety	☐	☐
Depression	☐	☐
Sleep Issues	☐	☐
12a. MALE/Genitourinary	**PR**	**PA**
Urinary Dribbling	☐	☐
Reduced Flow	☐	☐
Nighttime Urination	☐	☐
12b. FEMALE/Genitourinary	**PR**	**PA**
Abnormal Pap Smear	☐	☐
Urinary Complaints	☐	☐
Blood in Urine	☐	☐
Menstrual Irregularities	☐	☐

☐ **I have none of the above medical conditions**

SOCIAL HISTORY

	Never	Present	Past
1.Smoking	☐	☐	☐
Pack Years: ______			
2.Alcohol	☐	☐	☐
Drinks per day: ______			
3.Drugs ______	☐	☐	☐

MISC.

CONDITION	Y	N
Hepatitis A	☐	☐
Hepatitis B	☐	☐
COPD or Emphysema	☐	☐
Cancer	☐	☐
OTHER: ______	☐	☐

TELEMEDICINE CONSULTATION

Reviewed by Dr. Phil Johnson

To the best of my knowledge this is a complete and accurate account of my medical history.

Signature: ______ Date: ______

3 Rivers Pharmacy

IVERMECTIN DISCLAIMER

3537 N Anthony Blvd
Fort Wayne, IN 46805

(260) 373-1083
(260) 739-3927
morethanapharmacy@protonmail.com

I acknowledge and understand that Ivermectin has been deemed “Highly Not Recommended” by the WHO, FDA, CDC, and NIH. I acknowledge that my Clinicians rely on an appropriate medical and medication history relating to medical conditions and prescribed medications as reported by me as a patient.

Should a patient choose to not disclose their proper medical history, the clinician cannot be held liable nor can any medical license in any state be reviewed or held accountable. We will be explaining, to the best of our ability, the risks in prescribing any medications to the patients to which they must state they understand.

I understand that Ivermectin has not been approved for use for Covid 19 by the FDA at this time

Patient Signature

Print Name